NO. 45923-0-II
COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

STATE OF WASHINGTON, Plaintiff/Respondent, v. HAROLD BIRCUMSHAW Defendant/Appellant.	NO. **13-2-07068-1**

BRIEF OF APPELLANT

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7. Alternatively, did the State violate the Appellant's right to substantive due process in when it failed to acknowledge the Federal rules for Medicaid payments, rendering the administrative decision void?

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1. The Office of Administrative Hearings, its Board of Appeals and the Trial Court erred when they each refused to apply Federal and State Medicaid payment policies that require payment for covered, medically necessary services substantiated by the State's own medical records.

a. The Administrative Law Judge and the Board of Appeals in its final order erred when they refused to properly acknowledge the State's medical records exhibits when upholding the audit conclusions.

b. The Administrative Law Judge, Board of Appeals in its final order and the Superior Court erred when they refused to acknowledge that the exhibits, medical records, chart notes and patient records documented the provision of covered, medically necessary optometric services.

2. The Department's decision and the Appellate Division's modification of the decision are so internally inconsistent that the remaining audit decision requesting repayment of $224,114.64 out of $356,000 paid must be reversed.

3. The decisions of the Department, its Appellate Division and the Superior Court should be reversed because of the Department's failure to abide by Federal Medicaid payment rules violated Appellant's substantive due process rights, resulted in a punitive confiscation and ignored the effect of audit's internal inconsistencies.

IV. Issues Pertaining to Assignments of Error

1. Did the Office of Administrative Hearings, its Board of Appeals and the Trial Court err when they each refused to apply Federal and State Medicaid payment policies that require payment for covered, medically necessary services substantiated by the State's own medical records?

a. Did the Administrative Law Judge and the Board of Appeals in their final orders err when they refused to properly acknowledge the State's own medical record, exhibits when upholding the audit conclusions?

b. Did the Administrative Law Judge, the Board of Appeals in its final order and the Superior Court err when they refused to acknowledge that the exhibits, medical records documented the provision of covered, medically necessary optometric services.

2. Is the decision of the Office of Administrative Hearings and the Appellate Division's modification of the decision so internally inconsistent that the remaining audit decisions requesting repayment of $224,114.64 out of $356,000 paid must be reversed?

3. Should the decisions of the Department, its Appellant Division and the Superior Court be reversed because of the Department's failure to abide by Federal Medicaid payment rules violated Appellant's substantive due process rights, resulted in a punitive confiscation and ignored the effect of audit's internal inconsistencies?

V. Statement of the Case

A. Procedural History

Beginning July 12, 2007, the Washington Department of Social and Health Services conducted an audit of the billing records of the Petitioner, Harold Bircumshaw, O.D. Administrative Hearing Exhibits, 8, 9, 12, 20 The audit was completed and a final audit report issued on April 28, 2009, alleging four findings of an actual overpayment totaling about $11,168.50, Exhibit 29. The State extrapolated from this data to project an overpayment of $224,114.64, Exhibit 27, RP1: 132.

Dr. Bircumshaw requested an administrative hearing of the audit on May 20, 2009 and a hearing was conducted over several days. RP Volumes 1-16. The Administrative Law Judge affirmed the audit findings in her decision and initial order issued May 12, 2010. Dr. Bircumshaw filed a petition for review of the initial decision with the DSHS Board of Appeals on June 15, 2010. The Board of Appeals issued a final order on December 3, 2012. CP 1-80. Two of the four administrative findings were overturned and two were upheld in the Final Order dated December 3, 2012. Both parties filed motions for reconsideration and a decision and order on reconsideration was issued on February 8, 2013, denying both requests.

Appellant petitioned the Pierce County Superior Court for review of the amended administrative decision on March 8, 2013. CP 1-80. Judge

John Hickman affirmed the revised decision on January 13, 2014. CP 6489-6491. This appeal was filed February 10, 2014. CP 6494.

The administrative record in this matter consists of 16 volumes covering over 3,500 pages together with over 400 exhibits. The hearing included nine days of testimony and argument. The numbered exhibits and audit summary refer to a "record number" which designates the patient. The exhibits also have Bates stamp numbers on them. Wherever possible reference will be made to the exhibit numbers and Bates numbers as well as the record of proceedings including the volume and page number.

B. Substantive Facts

Harold Bircumshaw, O.D, is a provider of optometric services and licensed in the State of Washington. He performed optometric services for patients while employed by or operating Tacoma clinics. CP 1-80; Final Order. Patients included persons eligible for services under the federal Medicaid program administered by the State of Washington. Services included examinations, diagnoses, prescriptions, ordering of glasses and contact lenses, referrals and repair of existing eyeglasses. Patients presented their Medicaid coupon to Dr. Bircumshaw which authorized him to provide covered services at rates allowed by the state. Exh. 6. Dr. Bircumshaw signed a provider agreement with the state of Washington to provide optometric services to eligible patient recipients of Medicaid. By

signing this agreement, both parties agreed to follow Federal and State guidelines. DSHS, Exh. 6.

Medicaid patients would present their current medical coupon from the Department of Social and Health Services to the provider prior to services being received. RP 2, pp 14-187, Testimony of Oridione. Dr. Bircumshaw would conduct an examination, make any requisite diagnosis, prepare a prescription, order glasses or contact lenses, and make any necessary hardware repairs or provide authorized services to the patient. Prescription orders for glasses were then sent to the sole authorized provider of eyeglasses and contact lenses, Airway Optical in Airway Heights, Washington. Airway Optical provided a second confirmation of the recipient's eligibility by checking their records to determine when previous services had been provided for glasses or contact lenses. RP 6: 100-102. If federal or state guidelines were not met, Airway would refuse the order and return it to the provider. If documentation in the record indicated that the order would be eligible by adding an Expedited Prior Authorization (EPA) code, then the proper code was added and the order resent to Airway Optical. EPA codes were created and are required by the state when eyeglasses or contacts were lost, broken beyond repair, the prescription changed by more than .50 diopters, or the lenses were scratched or missing. RP 6: 100-102.

When the state Medicaid service office is billed by the provider for services rendered a procedural code (CPT) is indicated on the billing form (CMS 1500). These codes are copyrighted by the American Medical Association (AMA) and are provided in the CPT Coding Manual that is produced by the AMA. The full coding text was not made an exhibit. See ATR 4.57, page 29, Fn. 11. Common optical CPT codes include 92004 and 92014, routine examination for new and established patients; 92015 Refraction or prescription for eyewear; 92310, fitting contact lenses; 92340, fitting of single vision spectacles; 92341, fitting bifocals; 92370 repair of eye ware; and 92390, supply of materials for spectacle repair. Par. 4.26, Page 8, Exh. 92 and 93. This is only a partial list because the extensive CPT codes are copyrighted by the American Medical Association. The CPT codes are incorporated into the Washington Administrative Code, WAC 388-502-0100 et seq. The vast majority of optometric diagnostic work is described in about 10 CPT procedural codes. RP 6: 46-48; 108.

During the audit process of the SURS reports, definitions of copywritten CPT codes were truncated or changed by the state's audit team. Providers are required to use CPT manuals and the state's Billing Manual as their guideline for determining the correct billing codes. RP 1:82-84. While the state can and does impose certain regulations by statute and administrative rule, nevertheless the state is still bound by the

federal rules. Federal regulations refer to "records" with little or no explanation as to what the term means or records documentation methods. 42 CFR 433.304, 447645 (f) and .455.2. The state admitted that they have no written policies regarding the recording of documentation. RP 6:72. WAC 388-502-0100 et seq sets forth the elements that are to be documented, but fails to include any specifics about what format must be used. Therefore a provider can reasonably conclude that the provider's state and federal documentation requirements are fulfilled when a patient file is kept as a record and contains documentation elements as set forth in the medical records for each service.

Patient visits to an optometrist generate multiple different kinds of records including examination forms, which can include a written prescription with refraction data, state approved Airway optical ordering forms, referral requests from primary care providers (PCP), a referral request from an optical provider to PCP or other specialist, responses by providers to or for requests, examination forms regarding post-operative or follow up care, etc. Not every patient visit or contact generates the same kind of record, however included in the records and exhibits in this matter were 138 out of 171 (80.7%) in which the Airway order form was provided. See Exhibit 27, page 8, Bates #: 781.

The Airway Optical order form is significant because it is, in fact, a part of the patient record and contains all of the required documentation

elements of WAC and federal regulation regarding record keeping. The court may examine Exhibit N, Record # 111, Appendix A herein, which is a medical record and order form that is sent to Airway Optical for processing spectacle glasses. This exhibit has the following characteristics:

1. It specifically calls itself a "Medical Record."

2. It provides an order number issued by the state of Washington.

3. The State of Washington designed the form.

4. Use of the form is mandatory for both the provider of the hardware, Airway Optical, and for the optometrist, Dr. Bircumshaw.

5. The form provides the patient's name, date of birth, age, state issued ID number, address, month eligible for services, and services allowed.

6. The form may provide a prior authorization number issued by the state of Washington for eligible Medicaid participants.

7. The form contains the provider number assigned exclusively to Dr. Bircumshaw.

8. The form contains the order date or date of service.

9. The form contains optometric diagnostic information for both eyes, a prescription, and the pupillary distance between the eyes, abbreviated PD, test results, care plan and lens grinding instructions.

10. The form contains frame style and measurements of eye size, distance between lenses (DBL), the frame's temple length and temple type. These are physical characteristics unique to each patient and thus a medical record. Not only do these elements found on the Airway Optical order form satisfy state and federal requirements for documentation, the State itself refers to these forms as "medical records." Initial Order, Pages 9-10, dated May 12, 2010.

11. Contact lenses require much of the same information, but tailored for contact lens prescriptions and orders

Redacted copies of medical record order forms designated as DSHS exhibits and the DSHS medical coupon are attached hereto as Appendix A for ease of reference. They are record numbers 17 and, 111 and 113.

The Washington State Department of Social and Health Services (hereinafter "DSHS" or the "Department") conducted a payment audit of Dr. Bircumshaw's practice for the three years between June 2, 2003 and May 31, 2006. RP Bates #000140, Final Order, ¶15. As a result of that audit DSHS concluded that $233,028.66 of a total DSHS payment of $356,407.35, or about 65% of all reimbursement, over that three-year period should be repaid. RP Bates #000350, Initial Order, ¶4.22. The severity of this position was particularly striking since it did not rely on any assertion that the services billed were not medically necessary, that the

beneficiaries were not eligible for service, that the provider was not contracted to provide those services or that the services were not provided. RP 6:31. Counsel for the Department asserted "This [action] certainly isn't a challenge to Dr. Bircumshaw's quality of care or respect for his patients." RP. Vol 1, p. 68, Lines 19-21. The Department did not care whether the services were provided or not. RP. Vol 1, p. 60, Lines 1-25. Counsel for the Department stated "nobody's going to be asking you whether or not the services were provided." Id. She further commented "The Department...has not attempted to comment on at all whether services...were provided or not..." Id. p. 51, Lines 1-13.

The Department demanded that Dr. Bircumshaw repay 65% of his total reimbursement, accumulated over a three-year period, delivering medically necessary services, because his medical records were not maintained in a manner desired by the Department.

The DSHS audit had four stated objectives:

1. To determine if the services billed and paid were provided
2. To provide a method of determining compliance with state and federal regulations
3. To identify provider billing and/or payment irregularities
4. To provide a mechanism for data gathering to establish and/or modify policies and procedures RP Bates # 000347, Initial Order, p. 4, ¶4.10; RP Bates 000139, Final Order, p. 4, ¶10.

The audit findings were not categorized according to these objectives so it is not easy to discern how each was approached or to what extent each was accomplished. Objective #1, which claims the

Department will determine if the services billed and paid were actually provided, is particularly important to differentiate between errors and fraud. The Department's own attorney affirmatively ignored this objective by the above statement. The Department asserted that this objective was not of concern, though it is nonetheless a stated audit objective. The Medicaid Fraud Control Unit pursued the first objective by surveying historic patients regarding the services they obtained. RP Bates # 000301-306, Attachment K. The results of the survey were not released. The Department asserted that an invisible patient confidentiality barrier cannot be crossed for it to obtain its own records in order to determine if services were rendered. The Department offers no insight as to why it does not seek to verify if billed services were delivered. No facts were produced which proved that reasonable and necessary medical services were not provided by Appellant.

No evidence was provided at all as to whether DSHS pursued objective #4 and the remaining findings were not categorized in a manner that reveals which findings were associated with which objective, if any. The audit plan did not provide any further description as to how objectives 2 or 3 would be measured or how DSHS would know if the objectives were obtained. The Court and the Appellant are left to speculate from the results and the audit report what these objectives were intended to measure and if the objectives were obtained.

The confusion DSHS exhibited concerning its stated objectives helps to understand why the resulting findings are equally confusing. The internally inconsistent decisions, reversing some of the findings based on the presence of medical records while making other, contradictory findings in the face of the same medical record evidence requires reversal of this order.

After outlining the objectives of the audit, DSHS defined its scope: to measure compliance with regulations. RP Bates # 000348, Initial Order, pg5, ¶ 4.13; RP Bates #000000140, Final Order, p. 5, ¶ 14. This statement suggests that the only objective pursued was objective #2: provide a method of determining compliance with state and federal regulations. However, the results of the audit are expressed in terms of various "findings" that are not associated in any direct manner with regulations at all.

The audit resulted in four general and 11 more specified "findings." These were: 1) patient record lacked sufficient documentation; 2) incorrect exam code; 3) fitting of spectacles billed with repair and refitting; and 4) erroneous billing. RP Bates #000151-170, Final Order pgs 16-35. Findings #2 and #3 were dismissed by the State's own Appellate Division and were not advanced by the State on judicial review. The dismissal of findings 2 and 3 destroys the validity of the remaining findings because they all have the same factual basis in the audit.

A recap of the audited records which were overturned in the reversal of Findings 3A and 3B is attached hereto as Appendix B. The full list of findings correlated to the Appellate reversal is in the State's Exhibit 27, Bates #s 789-828.

In only two instances does DSHS associate any general or specific finding with a violation of a regulation. RP Bates # 000158, Final Order, p. 23, ¶69; p. 24, ¶71. Furthermore, DSHS fails to cite any criteria by which determinations were made leading to these "findings." When asked, the Department acknowledged that there are no written policies describing what is and is not acceptable documentation for services rendered. RP Vol. VI, p. 54, ¶¶2-9. The only guidance provided by DSHS is in the Billing Instructions that by the Department's own admission is limited to mimicking WAC 388-502-0020. RP Vol. 1, p. 168, ¶¶4-12. DSHS has no other guidance or criteria regarding documentation.

The findings appear to be based on the assertions of auditors who lack clinical expertise or legal training. RP Vol. I, p.80, ¶14; RP 6:25. For example in paragraph 52 of the Final Order the auditors assert:

> "The Core Provider Agreement requires the provider to keep complete and accurate medical and fiscal records that justify and disclose the extent of the services or items furnished and submitted to the Department."

This assertion is made without any reference to an audit objective or any authority as to how the assertion might apply to DSHS payment obligations. The Department provided no foundation as to how the core provider contract, establishing a provider's right to participate in the Medicaid program, is related to the Department's obligation to compensate providers for medically necessary and covered services to eligible beneficiaries. The Department's position ignores its own Airway Order Form that it calls a medical record.

The Core Provider Agreement further states "[I]f a provider provides services to an eligible client then the provider shall be paid." (Emphasis added). It allows but does not require, recoupment by saying "if services are not properly documented an over payment can be recouped by the Department." So, if no evidence exists that services were not provided then payment was mandatory and recoupment is not

The lack of experience in clinical optometric practice in the audit participants lead to audit conclusions not based on any discernible medical criteria. No individual with any optometric clinical experience participated in the audit. Determinations of clinical coding, correctness of exam codes, and sufficiency of documentation were being made by auditors without optometric clinical knowledge or experience. RP Vol VI, p. 31, ¶¶ 24-25. (DSHS Opening Brief, Exhibit 12, pgs. 6 and 14). The

only experience the audit team had with the specialty of Optometry was a single audit conducted by a consultant who was involved in auditing an Optician. Id. The team of four auditors was made up essentially of technicians, acting by rule rather than actual knowledge or experience with the particular service they were auditing. This process is in contrast to the process established by DSHS to evaluate quality of care.

> Utilization Review (UR) is a concurrent, prospective, and/or retrospective (including post-pay and pre-pay) formal evaluation of a client's documented medical care to assure that the healthcare services provided are proper and necessary and are of good quality. The review considers the appropriates of the place of care, level of care, and the duration, frequency, or quantity of healthcare services provided in relation to the condition(s) being treated. HRSA uses InterQual ISDR Level of Care criteria as a guideline in the utilization review process.

Physician Related Services, Billing Instructions, 2000, p. 32. (Emphasis added)

Utilization review and quality review rely on established clinical criteria. This is in stark contrast to the manner in which this billing audit was conducted. DSHS did not survey community standards of practice for Optometry and Optometrists. The Department did not solicit the input of the American Optometric Association. Rather, the Department forged ahead with an audit of an unfamiliar service with unclear objectives and a lack of criteria for the findings it asserted.

The Department's findings are subjective judgments contradictory to their own record forms. For example, in paragraph 53 of the Final

Order (Bates #000151) CP 1-80, the Department asserts: "Neither of the documents found in S14 is a chart note that justifies the billing for a refractive state." There is no foundation given for that judgment and, in fact, the judgment is false. The Department further asserted "An Airway Order is simply documentation an order was placed." This ignores the Department's own name for its own record and the presence of the records in over 70% of the cases analyzed. Airway Optical is the single contractor permitted by the Department for ordering vision hardware. Department Exhibit 32, Billing Instructions, pg. v. Airway Optical confirms that a hardware order falls outside of the required waiting interval between orders. Id. p. E.2. Airway requires that the order form be filled out completely, including a copy of the Medical ID card. Id. Finally, the Airway Optical order form is called a Medical Record.

Ms. Ordiorne testified that the Airway Optical order form was not recognized or accepted by the state as documentation or a chart note and that the Airway order was not a chart. RP 1, pages 14-187; Initial Order, Bates # 000152, Final Order P. 17, Par. 53. Given the state's own record description and the wealth of patient information this conclusion is erroneous. Ms. Ordione conceded that she did not know what information a state medical coupon contained. She testified that the state just did not recognize the Airway Optical order form or its contents as documentation. This begs the question. The State's own form designated these documents

as medical records. Words such as "records", "documentation", and "chart notes" have already been defined by state and federal laws and regulations. State regulations do not prohibit the use of the Airway order form as documentation in a patient's medical record, charts and file. The State itself uses the term "Medical Record" and relied on the information contained in Dr. Bircumshaw's patient files to determine reversal of Findings 2, 3A and 3B.

The Department's only citations of authority for how "chart notes" relate with authority for DSHS to deny payment are "Exhibits 30 and 31." Bates 144-146, Final Order pgs. 9-11. However, these exhibits are both titled "Documentation guidelines for Evaluation and Management Services," without citation of authorship or authority. There is no indication why these references should be recognized or controlling on the issue of whether services were properly provided by Appellant. The Appellate Division Final Order dismissed findings 2 and 3, related to evaluation and management services, for this very reason. Thus the only reference provided relating to "chart notes" was dismissed. No other authority is cited as to how "chart notes" relate to authority for DSHS to deny or recoup payment for services rendered.

The office of Administrative Hearings Appellate Division final orders dismissed the initial findings 3A and 3B. Of the remaining findings, Number 1 alleged inadequate documentation and finding number

4 alleged erroneous billing. These two categories account for approximately 90% of all the claims and 81% of the alleged overpayment.

The audit reviewed 348 samples out of 9,531 procedures or 3.65% of the total procedures during the relevant period. Initial Order ¶ 4.15, pp. 5-6. These 348 procedures had paid to Dr. Bircumshaw a total of $16,716.87, later reduced to $11,703.11. ID., Par. 4.15, Pages 5-6. From the 348 procedures reviewed the state used an extrapolation process to conclude that the state had erroneously paid for 9,506 procedures and from that small sample extrapolated that the resulting overpayment was $352,808.32, later reduced to $224,116.64. RP 1: 15, 17. The initial administrative ruling referred to four different components or findings of the audit to which components have two subparts and a third component having three subparts. See Appendix B, Projected Sample Overpayments.

Dr. Bircumshaw sought review before the Office of Administrative Hearings, Appellate Division. The Appellate Division modified the order of Judge Peterson by eliminating certain findings in the order. Findings 2, 3A and 3B were reversed. Review Decision, December 3, 2012. This reversal affected 41 records or 10.8% of the total sample reviewed. These findings were reversed based on the fact that "records" existed and were part of the evidence produced during the administrative hearing. The state had taken the position at the hearing that documentation, chart notes, and records did not exist. Medical records, chart notes and documentation

were provided for the auditor's review and copied by the state for use as exhibits. These records account for over 95% claimed audit failures. The state did not appeal the reversal of these findings.

The State's professed goal was to insure that the sample selected insured a minimum of 95% confidence level. Initial Order, Par. 4.12, at Page 5. In reversing a portion of the initial decision the OAH Appellate Division rejected 25 of the claims because the State had simply added those claims to the projected amount. Exh. 20, Page 8. This represented about 8% of the records reviewed. Many records were removed from consideration, after the 95% level of confidence was alleged to have been attained, and before the audit hearing started. Add those records to the 25 claims above and a significant number of claims were removed from consideration, therefore the 95% level of confidence was lowered, and mitigated to a significantly debased amount. Moreover, similar or identical claims that were included in Findings 1A and 1B and 4 that would further downgrade the confidence level because the documentation, medical records and chart notes do exist as the Department's Appellate Judge found in reversing findings 2, 3A and 3B based on the fact that documentation did exist.

During cross examination Sally Ordione conceded the following facts:

1. She had very limited experience in the ophthalmology field, RP 6:25;
2. She was not aware of any outside patient complaints, RP 6:31;
3. The CPT codes were abbreviated, RP 6, 46-48, and dispensing of glasses had different codes, RP 6: 52-53;
4. The Airway order forms did not disclose ordering intervals, RP 6: 56, 58 and treatment could be considered the prescription in the order form, RP 6: 80;
5. She could provide no statutory definition of a "medical record", RP 6:72.

The Department's citation of legal authority for these findings is as confusing as its stated objectives in its audit. Despite that the Department outlined objectives and categorized findings, in fact all results were defined in terms of "overpayments." Somehow the audit objectives morphed into an audit for overpayments. Overpayments are defined in both the Initial Order and the Final Order as "payments greater than the payment owed." Bates 184, Final Order p. 49, ¶ 30. However, neither the Final Order, nor the Initial Order, nor the Department itself provide any authority at all of what "payment" is owed, on what authority it is owed, by what criteria it is owed, or on what authority is the Department allowed to deny payment for medically necessary and covered services provided to eligible enrollees. The hearing does not demonstrate the elements of what

constitutes an improper payment. If the State's own medical records demonstrate the provision of services, no over payment existed. Judge Peterson formed the issue precisely this way when she stated that the real issue was whether the services were provided, RP 4: 67-68.

The Department offered no proof or differentiation of "proper" or "improper" payments. Rather, its claim rests on the auditors' findings of non-compliance with a regulation. RP, Vol II, p. 16, lines 18-20. Although it is never actually articulated, the Department appears to argue that since certain documentation is required to justify payment, a finding that certain documentation is lacking justifies recoupment of payments whether or not the service was medically necessary and actually delivered to an eligible beneficiary. The Department failed to define documentation and failed to identify objective criteria to judge the adequacy of documentation. Its own order form document is a medical record.

The only guidance the Department provided regarding documentation is from the Vision Care Billing Instructions. RP, Vol VI, p. 72, Line 24. However, the only reference in those billing instructions is a recitation of the exact terms of WAC 388-502-0020. RP, Vol I, p. 167, Line 20 & p. 168, Line 12. This regulation (the only guidance provided on "documentation") is a list of documentation categories. The Department's guidance was completely devoid of specification of where documentation was to be kept, how recorded, how detailed, or how related

or unrelated to billing records. The Department acknowledged that it had no objective criteria of what constitutes adequate or inadequate documentation. RP, Vol VI, p. 54, Lines 6-9. The Department is left to rely on non-clinical auditors inexperienced in the service of Optometry making arbitrary judgments as to the adequacy of documentation.

There are many examples of the Department's arbitrary conduct. A "finding" was defined as where the auditor (non-clinical, inexperienced and without guideline) determined there is an error. RP, Vol II, p. 16, Lines. 18-20. The Department utilized CPT procedure codes for designation of the service billed. The Department worked around the requirement that the State pay for a license to use these codes by "truncating or shortening the descriptions." RP, Vol I, pgs. 123 – 124. However the Department arbitrarily added additional undocumented and unpublished service requirements to CPT codes. See example for CPT 92370, Repair and refitting spectacles, in which DSHS adds the service requirement of "dispensing". RP. Vol VI, p. 50, L. 22 – p. 52, L. 11. The Department refused to recognize a data rich Airway Optical Order, see infra, as documentation. RP, Vol VI, p. 55, L. 4. The Department refused to consider Transaction Histories or any information from the Optometrist's electronic billing system as documentation. Bates 000156, Final Order, p. 21, Par. 65.

The Department's claim that alleged inadequate documentation justified recoupment of payments is a policy *failed to define any resulting damage*. There is no rational association between the alleged documentary inadequacy and the value of any actual resulting damage, if any. The Department's allegations of violation are completely devoid of any reference to damage at all. The Department never demonstrated that the services and hardware were not actually provided to eligible recipients. Specific Findings of the Final Order (beginning at Bates # 000151, on page 16). Finding 1 ¶53 – Code 92015 This sub-finding involves only 1 claim, No. 61. CPT code 92015 designates the measurement of the refractive state. DSHS asserted that there was no chart note verifying the refractive state was measured. Dr. Bircumshaw provided an Airway Order identifying the refractive state measurements taken on the patient, the date those measurements were taken, and the date Airway shipped the resulting glasses. DSHS asserted this documentation "is [not] a chart note that justifies the billing for a refractive state," though no authority defines what does and does not constitute a "chart note."

¶54 – Code 92082. This sub-finding involves only 1 claim, No. 316. CPT code 92082 designates a visual field examination with interpretation and report. Dr. Bircumshaw conducts this exam on a device that automatically generates the interpretation and report. The report has an auto-date field as well. The auto date field stated "1998." Dr. Bircumshaw had

handwritten the date May 4, 2005, on the top of the report. Without explanation the Department asserted the handwritten date is insufficient to overcome the auto-produced date. Thus the Department unilaterally changed the medical record without any basis.

¶s 55and 68 – Code 92310. This sub-finding involves 16 claims. CPT code 92310 designates the fitting of contact lenses. The Department presents two reasons for denial of these claims: 1) no evidence of prior authorization, and 2) no chart note justifying delivery of the service (a requirement arbitrarily added by DSHS outside of the AMA definition of CPT 92310, without publication or notice)

DSHS acknowledged in its finding that the only claims under this CPT code that require prior authorization are claims for repeated service within 2 years. Final Order, ¶68. Airway Optical rejects and returns orders for clients with unauthorized orders within the 2 year cycle, Exhibit 32, Billing Instructions, p. E.2, so the assertion regarding prior authorization is a red herring. Where the service was within the 2 year cycle, the Airway Optical order includes the authorization number. See claim # 190. Finally the authorization number is provided by DSHS which retains the record.

The first claim cited under this finding is claim #8. The Department does not discuss this claim on the record; however the documentation is included on the record. The record for this claim

incudes both medical record notes and an Airway Order both identifying the refractive measurements ("fitting") taken on the patient.

This result is similar for the other claims cited in this finding ¶s 56, 69, 70, and 75 (Airway form needed to be obtained from Airway) – Code 93240 and 92341. This sub-finding involves nearly two-thirds of the claims in this matter. CPT code 92340 designates fitting of spectacles. Code 92341 designates fitting of bi-focals. Although the Department asserts these codes as involving dispensing, the AMA defines this code as "Fitting of spectacles" and specifically recognizes that "supply of materials is a separate service component; it is not part of the service of fitting spectacles." American Medical Association, Current Procedural Terminology, first cited in 1998 edition. The Department does not provide citation for its assertion. The large majority of these claims involve an Airway Order demonstrating the refractive measurement resulted in the order of hardware.

The Department variously asserts "An Airway bill is not evidence the spectacles were actually dispensed." However, there have been no patient complaints, and no complaints by Airway Optical. RP 6:31. The Department's fraud unit identified no allegations of misconduct. The Department provided no evidence the hardware that was ordered and supplied by Airway was not delivered and the Department had full access to Airway records to determine this fact. The Department asserted "To

justify billing...a provider must document... [including] facial measurements, evaluating and adjusting the physical fit of the hardware... Final Order ¶69. Each Airway Order provides just such measurements. ¶s 57-59, 71, 84 – CPT code 92370. This sub-finding involved approximately 10% of the claims. CPT code 92370 designates repair and refitting spectacles. It is similarly limited to 92340 and 92341 in that the AMA defined this code as specifically excluding dispensing.

The Department tried to rewrite the code. Dr. Bircumshaw maintained a stock of new Airway Optical frames allowed him to more quickly serve patients with broken frames by re-fitting properly fitted lenses into a frame on-hand, and then replacing the dispensed frame with the one provided by Airway. The Department asserted that this practice does not qualify as obtaining a frame from Airway. Instead, in order to have functional glasses a patient was required to wait until the replacement frame arrived in the mail; service on the spot with the exact same frame as the one that will arrive in the mail many days later was not permitted without reference to any WAC. The Department's demand for form over substance was not warranted by any regulation and was arbitrary and capricious.

¶ 102 Interval between claims: The Department denied a number of claims because it claimed to be unable to determine from the documentation whether the proper interval occurred since the last similar service. Final Opinion ¶102. The first section of claims is for CPT code

99205. This CPT code was dismissed as an evaluation and management code and is no longer on review. The Department's own billing instructions stated that Airway Optical confirms that a hardware order falls outside of the required waiting interval between orders. Department Exhibit 32, p. E.2. Medicaid patients change providers and fall in and out of coverage eligibility with high frequency but are free to choose their provider. The provider has no control over the frequency with which an individual Medicaid patient requests new glasses and thus cannot be penalized for the patient's acts. It is unfair and needlessly punitive for the Department to deny payment when documentation that the service met the interval requirement and there is no showing that Airway was denied payment or its payments recouped.

The remaining findings involve a small number of claims or findings that were dismissed. (Findings 2 – 3b, ¶s 76-85 were dismissed).

Dr. Bircumshaw's billing records more than adequately substantiated that his services were provided, billed and the services description were proper. No Airway Optical order was rejected because of improper coding nor did the Department reject the initial payment request.

The Department neither alleged nor cited any evidence that services were not provided or that there was any concern with the quality of service provided by Dr. Bircumshaw. *The Department can cite no damage that resulted from any of the alleged coding inadequacies.*

There is a question of simple fairness here. The Department is pursuing recoupment of 65% of all payments made over three years for alleged technical violations without any allegation of harm to the public or the department. There are no records of complaints by patients, no record that services were not delivered and so the only logical conclusion is that services were delivered.

VI. ARGUMENT

A. Standard of Review

R.C.W 34.05.570 provides for review of the orders of an administrative law judge. The statute provides:

> 1) Generally.
> Except to the extent that this chapter or another statute provides otherwise:
> (a) The burden of demonstrating the invalidity of agency action is on the party asserting invalidity;
> (c) The court shall make a separate and distinct ruling on each material issue on which the court's decision is based; and
> (d) The court shall grant relief only if it determines that a person seeking judicial relief has been substantially prejudiced by the action complained of.
> (3) Review of agency orders in adjudicative proceedings. The court shall grant relief from an agency order in an adjudicative proceeding only if it determines that:
> (a) The order, or the statute or rule on which the order is based, is in violation of constitutional provisions on its face or as applied;
> (d) The agency has erroneously interpreted or applied the law;
> (e) The order is not supported by evidence that is substantial when viewed in light of the whole record before the court, which includes the agency record for judicial

review, supplemented by any additional evidence received by the court under this chapter;
Or (i) The order is arbitrary or capricious."

Issues that involve statutory interpretation are reviewed de novo. *Dep't of Ecology v. Campbell & Gwinn, LLC*, 146 Wash.2d 1, 9, 43 P.3d 4 (2002). The fundamental objective in statutory interpretation is to give effect to the legislature's intent. Id. If a statute's meaning is plain on its face, the Court gives effect to that plain meaning as an expression of legislative intent. *State ex rel. Citizens Against Tolls v. Murphy*, 151 Wash.2d 226, 242, 88 P.3d 375 (2004). The Court discerns plain meaning not only from the provision in question but also from closely related statutes and the underlying legislative purposes. Id. If a statute is susceptible to more than one reasonable interpretation after this inquiry, then the statute is ambiguous and the Court may resort to additional canons of statutory construction or legislative history. *Campbell & Gwinn*, 146 Wash.2d at 12, 43 P.3d 4.

The Court gives effect to all statutory language, considering statutory provisions in relation to each other and harmonizing them to ensure proper construction. *King County v. Cent. Puget Sound Growth Mgmt. Hearings Bd.*, 142 Wash.2d 543, 560, 14 P.3d 133 (2000). The Court avoids construing a statute in a manner that results in "unlikely, absurd, or strained consequences." *Glaubach v. Regence BlueShield*, 149 Wash.2d 827, 833, 74 P.3d 115 (2003).

While substantial weight is given to an agency's interpretation of the law within its expertise, such as regulations the agency administers, *Silverstreak, Inc. v. Dep't of Labor & Indus.*, 159 Wash.2d 868, 885, 154 P.3d 891 (2007), Dep't of Labor & Indus. v. Granger, 159 Wash.2d 752, 764, 153 P.3d 839 (2007), the Court is not bound by an agency's interpretation, and "deference to an agency is inappropriate where the agency's interpretation conflicts with a statutory mandate." Id. "[R]ules that are inconsistent with the statutes they implement are invalid." Id. (quoting *Bostain v. Food Express, Inc.*, 159 Wash.2d 700, 715, 153 P.3d 846 (2007)).

B. 1. The Office of Administrative Hearings, its Board of Appeals and the Trial Court erred when each refused to apply Federal and State Medicaid payment policies that require payment for covered, medically necessary services substantiated by the State's own medical records.

a. The Administrative Law Judge and the Board of Appeals in its final order erred when they refused to properly acknowledge the State's medical records, exhibits when upholding the audit conclusions.

b. The Administrative Law Judge, the Board of Appeals and the Superior Court in its final orders erred when they refused to acknowledge that the exhibits, medical records, chart notes and patient records documented the provision of covered, medically necessary optometric services.

The Board of Appeals erred by conflating medical records with payment authority. The Board of Appeals stated the two are "inseparably intertwined" without ever establishing the traditional purpose of medical

records within the medical field and without any consideration as to how a relatively simple service of optometry would differ in the intensity of documentation requirements from that of dentistry, or internal medicine or cardiac surgery. This was the stated audit objective.

Medicaid Defined

Medicaid is a federal program, under which the state and federal governments share the cost of providing care for low income individuals. Crista Senior Community v. Department of Social & Health Servs. 77 Wash.App. 398, 400-401, 892 P.2d 749 (1995)(citing *Diversified Inv. Partnership v. Department of Social & Health Servs.*, 113 Wash.2d 1 9, 21, 775 P.2d 947 (1989)). Under this joint program, the federal government delegates authority to the states to administer Medicaid and to devise their own reimbursement systems, provided the systems comply with certain federal guidelines. Title XIX of the Social Security Act, codified at 42 U.S.C. 1396a, et seq.

Federal Medicaid Payment Policies

The Medicaid and CHIP Payment and Access Commission (MACPAC) was established in the Children's Health Insurance Program Reauthorization Act of 2009, and its charge was later revised in the Patient Protection and Affordable Care Act of 2010. Appointed by the U.S. Comptroller General, the 17 Commissioners have diverse backgrounds,

offer broad perspectives on Medicaid and CHIP, and represent different regions across the United States.

The Commission is a non-partisan, federal, analytic resource for the Congress on Medicaid and CHIP. MACPAC is the first federal agency charged with providing policy and data analysis to the Congress on Medicaid and CHIP, and for making recommendations to the Congress and the Secretary of the U.S. Department of Health and Human Services on a wide range of issues affecting these programs. MACPAC Report to the Congress on Medicaid and CHIP, June 2013, cover letter, accessed June 26, 2013 at http://www.macpac.gov/reports.

In 2011 the Medicaid and CHIP Payment and Access Commission reported to Congress that there existed no sources that systematically and comprehensively explain how states determine Medicaid payments or evaluate whether or not payments meet statutory requirements and promote value-based purchasing. MACPAC Report to the Congress on Medicaid and Chip, March 2011, p. 154, accessed June 26, 2013 at http://www.macpac.gov/reports. Medicaid payment policies are developed by each state with federal review limited to the general principles set forth in Section 1902(a)(30)(A) of the Social Security Act. Id. That provision requires that provider payments be consistent with efficiency, economy, quality, and access and safeguard against unnecessary utilization. Id. Within Medicaid "Abuse" is defined as:

> "Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care." 42 CFR 433.304 and 42 CFR 455.2."

The Medicaid Integrity Program was established in the Deficit Reduction Act of 2005 (P.L. 109-107). Program integrity is identified in Title XIX of the Social Security Act (the Act) as an essential program function, and all Medicaid programs must have "methods and procedures relating to the utilization of and payment for care and services....as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care" (42 USC 1902(a) (30)).

Section 1902(a)(30)(A), codified as 42 USC 1396a (30)(A), is the foundational statutory provision that governs federal review of state payment methodologies by Medicaid. Id. p. 159 and the statute provides, 42 USC 1396a(30)(A):

> "A state plan for medical assistance must] (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;..."

There are very few Federal regulations addressing Medicaid payment policy. 42 CFR Subpart F addresses requirements for states refunding of the Federal share of Medicaid overpayments to providers. It is the only Medicaid regulation that defines overpayment. Accordingly overpayment means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act. 42 CFR 433.304.

The DSHS Board of Appeals mis-stated the Federal regulation directing State Medicaid audits. The Board cited 42 CFR 447.202. That section specifies: "The Medicaid agency must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials." (Italic added). The payments in this matter were fee-for-service not based on cost of materials. The Federal Statute directing audits is actually 42 CFR 447.45(f) – Prepayment and Post-payment Claims Review. Accordingly "(2) The agency must conduct post-payment claims review that meets the requirements of parts 455 and 456 of this chapter, dealing with fraud and utilization control."

Federal policy is directed toward ensuring payment is made for necessary utilization and is consistent with efficiency, economy, and quality of care. There is no direction made or authorization established to withhold

payment for any technical reason. Payment is made to providers when they provide necessary service to eligible recipients.

Summary of Federal Medicaid Payment Policy

- At least as of 2011 there were no sources that evaluate whether state payments meet statutory requirements.
- State policies are developed with Federal review to enforce the principles set forth in Section 1902(a)(30)(A)
- Section 1902(a)(30)(A) directs state plans to safeguard against unnecessary utilization and to assure that payments are consistent with efficiency, economy, and quality of care

State Statutes and Regulations

Consistent with the generality of Federal policy guidelines, Washington State also characterizes Medicaid payment policy in general terms. During the years of 2002 to 2006 the State of Washington defined the term "overpayment" for the purposes of Medicaid reimbursement in chapter 43.20B RCW, Revenue Recovery for Department of Social and Health Services. Specifically "overpayment" means any payment or benefit to a recipient or to a vendor in excess of that to which is entitled by law, rule, or contract... RCW 43.20B.010(5).

RCW 74.09.200, Audits and Investigations, authorizes DSHS to audit the records of providers of service and provides:

> The legislature finds and declares it to be in the public interest and for the protection of the health and welfare of the residents of the state of Washington that a proper regulatory and inspection program be instituted in connection with the providing of medical, dental, and other health services to recipients of public assistance and medically indigent persons. In order to effectively accomplish

> such purpose and to assure that the recipient of such services receives such services as are paid for by the state of Washington, the acceptance by the recipient of such services, and by practitioners of reimbursement for performing such services, shall authorize the secretary or director, to inspect and audit all records in connection with the providing of such services.

The purposes of the authorizing statute are: 1) to protect the health and welfare of the residents of the state; 2) to assure that the recipient of such services receives such services as are paid for by the state; 3) to assure acceptance by the recipient of such services; and 4) to assure the acceptance of reimbursement for performing such services by practitioners. None of these purposes suggest granting any authority to DSHS to deny payment to practitioners for medically necessary services to covered individuals for technical violations unrelated to the provision of such service.

The Department itself established a regulation providing the guidelines for review of providers as authorized under RCW 74.09.200. As authorized by chapter 74.09 RCW, the medical assistance administration (MAA) monitors and reviews all providers who furnish medical, dental, or other services to eligible medical assistance clients. MAA determines whether the providers are complying with the rules and regulations of the program(s) and providing appropriate quality of care, and recovers any identified overpayments.

WAC 388-502-0230.

The regulation continues and specifies the 8 remedies available under the regulation:

> (3) MAA may determine that a provider's billing does not comply with program regulations or the provider is not meeting quality of care practices. MAA may do, but is not limited to, any of the following:
> (a) Conduct prepay reviews of all claims the provider submits to MAA;
> (b) Refer the provider to MAA's auditors (see WAC 388- 502-0240);
> (c) Refer the provider to Medicaid's Fraud Control Unit;
> (d) Refer the provider to the appropriate state health professions quality assurance commission;
> (e) Impose provisional stipulations for the provider to continue participation in medical assistance programs;
> (f) Terminate the provider's participation in medical assistance programs;
> (g) Assess a civil penalty against the provider, per RCW 74.09.210; and
> (h) Recover any monies that the provider received as a result of inappropriate payments.

The regulation does not define "inappropriate payments." The Federal authorizing statutes provide authority to the states only to safeguard against unnecessary utilization and to assure that payments are consistent with efficiency, economy, and quality of care. 1902(a)(30)(A). By this authority inappropriate payments would be payments for unnecessary utilization or inferior quality of care. Though neither is questioned in this matter, the Department does allege "overpayments."

RCW 43.20B.010(5) defined "overpayment" *as any payment or benefit to a recipient or to a vendor in excess of that to which is entitled by*

law, rule, or contract... "The rules for Medicaid payment policy are described only in separate regulations, and in particular in WAC 182-502: Administration of Medical Programs – Providers. The foundational regulation for provider compensation under Washington Medicaid is WAC 388-502-0010, Payment – eligible providers defined:

> **"The department reimburses enrolled providers for covered medical services equipment and supplies they provide to eligible clients.**
> ...
> (2) To enroll a provider must sign a core provider agreement... The department and each provider signing a core provider agreement will hold each other harmless from a legal action based on the negligent actions or omissions of either party under the terms of the agreement."
> The general conditions of payment are provided in WAC 388-502-0100:
> The department reimburses for medical services furnished to an eligible client when all of the following apply:
> a) The service is medically necessary;
> b) The service is properly authorized
> c) The provider bills according to the department rules and billing instructions; "

These two regulations codify a payment policy that is entirely consistent with the federal guidelines; that is **the department will reimburse enrolled providers for medically necessary services delivered by enrolled providers**. Inappropriate payments, or overpayments, would be for services not medically necessary, not properly authorized or not "billed" according to departmental rules. Thus reimbursement is dependent upon "Billing" according to departmental

rules and billing instructions; not "documenting" according to departmental rules. No other statute or regulation specifies the bases of "entitlement" to payment.

Finally, WAC 388-502-0020 states that enrolled providers must keep legible, accurate and complete charts and records to justify the services provided to each client... including the following:

> (i) Patient's name and date of birth;
> (ii) Dates of services;
> (iii) Name and title of person performing the service, if other than the billing practitioner;
> (iv) Chief complaint or reason for each visit;
> (v) Pertinent medical history;
> (vi) Pertinent findings on examination;
> (vii) Medications, equipment, and/or supplies prescribed or provided;
> (viii) Description of treatment (when applicable);
> (ix) Recommendations for additional treatments, procedures, or consultations;
> (x) X-rays, tests, and results;
> (xi) Dental photographs and teeth models;
> (xii) Plan of treatment and/or care, and outcome; and
> (xiii) Specific claims and payments received for services

Other than this generic list of categories the department does not provide any further guidance regarding what it considers adequate documentation. The Department does provide certain guidance regarding "billing." For both Vision Care and General Physician Providers there are specified Billing Instructions. The Vision Care billing instructions do not address medical records at all. They do refer providers to the DSHS General Information Booklet. Healthcare record requirements in the

General Information Booklet are limited to the following quoted statement:

> *The complete list of Healthcare Record Requirements can be found in WAC 182-502-0020.* (The same as WAC 388-502-0020) General Information Booklet; Understanding Policies Regarding Enrolled Providers; page 12.

This single WAC and its generalized categories provides the only record keeping guidance for the provider, guidance that Appellant met with the Department's own "medical record." Washington's Medicaid payment policy provides that enrolled providers will be reimbursed for properly authorized, medically necessary and provided covered service to eligible clients, billed properly and reflected in the records. The Department agreed to hold the provider harmless for negligent acts or omissions. Based on the Department's own records, the federal standards and the language of the regulations the Administrative decision as modified and the Superior Court must be reversed.

C. The Department's Decision and the Appellate Division's modification of the decision are internally so inconsistent that the remaining audit decisions requesting repayment of $224,114.64 out of $356,000 paid must be reversed.

The department sought to recoup nearly 65% of all payments made over the course of three years. It based its demand largely on the quality of records kept by Dr. Bircumshaw. The department did not claim the services were not provided, or that they were medically unnecessary, or that the beneficiaries were not eligible. There is no allegation of fraud or

any intent to obtain payment for service not provided. The actual amount in the audit before the Appellate Division reduction was $11,703.11

The audit's projected sample of overpayments identifies those overpayments in Appendix B. The appendix is useful because it provides a finding number referring to the findings of fact in the ultimate administrative law decision. The Appellate Division reversed as to findings 2, 3A and 3B amounting to a total of 41 records or 10.8% of the audit. Exh. 20, Page 14, Bates # 677. This approach is inconsistent with the result of leaving other records intact but not reversing the decision of the administrative law judge. The actual amounts audited accounted for $11,703.11 of a total billed amount of $221,001.15 or 5.29%. Exh. 29, Page 4, Bates # 888.

Of critical importance are the records denominated in the findings under Findings number 1A and 1B and in the appendices. Finding 1A referred to the absence of records. The state only reviewed 41 cases in that category. In 10 or 24.39 % of the cases Airway Optical orders and other records existed. With only 75% remaining it is well below the 95% confidence level state alleges it met.

As for finding 1B, 128 cases or 98.46% of the 130 cases reviewed contained Airway orders. Of the combined total of 171 cases reviewed in findings 1A and 1B, 138 or 80.7% of the cases had Airway Optical orders

as part of the exhibits. These exhibits were introduced by the state itself and indexed herein at Appendix B.

A representative example occurs where the department cites billing for CPT code 92015, Determination of Refractive State. This procedure involves the measurement of the deviance of an individual's eyesight from a standard. It directs the supplier of eyeglasses which prescription is required.

Dr. Bircumshaw's records included the order he placed with the department's designated supplier indicating the refractive measurements he derived and the date of the order. The department maintains this is insufficient to substantiate that a refractive measure was taken. Bates #000151, Final Order, p. 16, ¶53. This is the type of discrepancy for the vast majority of the funds the department seeks to withhold.

Dr. Bircumshaw's records also include his patient calendar indicating which patients are seen at what times and dates. The calendar dates correspond to the dates on order forms placed with the department's designated supplier. The department contends this is an inadequate record to substantiate the timing of the visit and refractive measure. Id. Medicaid records are often comprised of multiple record forms, i.e. x-rays, nurses' notes, exam charts, lab reports and others. These medical records are no different. Dr. Bircumshaw maintained sufficient records to substantiate the services billed were provided.

The Department has no less than 8 options from which to choose in responding to a provider it finds to be out of compliance with program regulations or at risk regarding quality of care. WAC 388-502-230(3)(a-h). The question for the court is *if it is the proper remedy for the department to withhold payment or impose Draconian penalties for medically necessary, covered services, when the department is required to review records from a number of sources to verify the service*? The Department's approach ignores the controlling federal rules which mandate payment for covered, medically necessary services to eligible beneficiaries.

D. The decisions of the Office of Administrative Hearings, its Appellant Division and the Superior Court should overturned because the Department's failure to abide by Federal Medicaid payment rules violated Appellant's substantive due process rights, resulted in a punitive confiscation and ignored the effect of audits' internal inconsistencies.

Punitive damages are not permitted in Washington unless expressly authorized by the Legislature. Zuver v. Airtouch Communications, Inc., 153 Wash.2d 293, 330, 103 P.3d 753 (2004), citing *Barr v. Interbay Citizens Bank of Tampa, Florida*, 96 Wash.2d 692, 699, 635 P.2d 441, 649 P.2d 827 (1981). Damages are given as a compensation or satisfaction to the plaintiff for an injury actually sustained by him from the defendant. *Spokane Truck & Dray Co. v. Hoefer Et Ux.*, 11 L.R.A. 689, 2 Wash. 45, 53, 25 P. 1072 (1891). They

should be precisely commensurate with the injury, neither more nor less; and this whether it be to his person or his estate. Id.

Compensatory damages are intended to redress a plaintiff's concrete loss, while punitive damages are aimed at the different purposes of deterrence and retribution. *State Farm Mutual Automobile Insurance Co. v. Campbell*, 538 U.S. 408, 408-9,123 S.Ct. 1513 (2002). Because civil defendants are not accorded the protections afforded criminal defendants, punitive damages pose an acute danger of arbitrary deprivation of property, which is heightened when the decision maker is presented with evidence having little bearing on the amount that should be awarded. Id. p. 409.

DSHS neither alleged nor proved that it sustained any damage from the alleged documentation inadequacies of Dr. Bircumshaw. Compelling Bircumshaw to pay 65% of his earnings back to the Department without any allegation that services were not performed or that there was any question of quality is both arbitrary and a punishment. The Department has not suffered any damage in this matter and damages associated with punishment are not available as a remedy in Washington.

E. Providing Service Without Compensation Generates an Unjust Enrichment For the State

Washington Courts analyze restitution obligations in a manner analogous to tort or contract, Davenport v. Washington Education Association, 147 Wn.App. 704, 1726, 97 P.3d 686 (2008). Unlike the law

of conversion, which requires that the transferee have wrongfully received the property of another, the law of restitution requires only that the transferee have received the property of another under circumstances that result in the transferee's "unjust enrichment." Id.

In the present matter the Department does not dispute that medically necessary services were rendered to eligible beneficiaries. Thus, the Department obtained value for which compensation would serve as consideration. Were the Department to retain that compensation, the Department would receive value without cost. That cost would be borne by Dr. Bircumshaw who would be left in the position of being contractually obligated to provide services for which he would ultimately not receive any compensation.

There is nothing in the law or in the evidence presented to suggest that a proper motivation for DSHS is to enlist medically necessary services with the ability to withhold compensation for technical reasons not associated with the quality or volume of service provided.

F. DSHS Withholding of Payment is a Violation of Substantive Due Process and Void As A Matter of Law

The Fourteenth Amendment of the U.S. Constitution holds that no state shall deprive any person of life, liberty, or property, without due process of law. Article 1, Section 3 of the Washington State Constitution provides that no person shall be deprived of life, liberty, or property, without due process of law. The due process clause of the Fourteenth

Amendment provides greater protection than does Article 1, Section 3, and the federal constitution must prevail. *Olympic Forest Products, Inc. v. Chaussee Corp.*, 82 Wn.2d 418, 421-422, 511 P.2d 1002 (Wash. 1973).

The Due Process Clause of the Fourteenth Amendment prohibits the imposition of grossly excessive or arbitrary punishments on a tortfeasor. *Cooper Industries, Inc. v. Leatherman Tool Group, Inc.*, 532 U.S. 424, 433, 121 S.Ct. 1678, 149 L.Ed.2d 674 (2001); *BMW of North America, Inc. v. Gore*, 517 U.S. 559, 116 S.Ct. 1589, 134 L.Ed. 2d 809 (1996); see also id., at 587, 116 S.Ct. 1589. (BREYER, J., concurring)

> ("This constitutional concern, itself harkening back to the Magna Carta, arises out of the basic unfairness of depriving citizens of life, liberty, or property, through the application, not of law and legal processes, but of arbitrary coercion").

The reason is that "[e]lementary notions of fairness enshrined in our constitutional jurisprudence dictate that a person receive fair notice not only of the conduct that will subject him to punishment, but also of the severity of the penalty that a State may impose." Id., at 574, 116 S.Ct. 1589; Cooper Industries, at 433, 121 S.Ct. 1678.

To the extent an award is grossly excessive, it furthers no legitimate state purpose and constitutes an arbitrary deprivation of property. *Pacific Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1, 19, 42, 111 S.Ct. 1032, 113 L.Ed.2d 1 (1991). Defendants subjected to punitive damages in

civil cases have not been accorded the protections applicable in a criminal proceeding. This increases our concerns over the imprecise manner in which punitive damages systems are administered. We have admonished that "[p]unitive damages pose an acute danger of arbitrary deprivation of property. *State Farm Mutual Automobile Insurance Co. v. Campbell*, 538 U.S. 408, 417,123 S.Ct. 1513 (2002). The Courts concerns are heightened when the decision maker is presented, as we shall discuss, with evidence that has little bearing as to the amount of punitive damages that should be awarded. Id. at 418.

In light of these concerns, in *BMW v. Gore*, supra, the Court instructed lower courts reviewing punitive damages to consider three guideposts: (1) the degree of reprehensibility of the defendant's misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases. *BMW of North America, Inc. v. Gore*, p. 575. These guideposts were reiterated in Cooper Industries, supra, and appellate courts were mandated to conduct de novo review of a trial court's application of them to the jury's award. *Cooper Industries, Inc. v. Leatherman Tool Group, Inc*.

In comparing punitive damages to compensatory damages in Haslip, a fraud case, a ratio of 4–to–1 was "close to the line" but did not

"cross the line. A 10–to–1 ratio was upheld in TXO Prod. Corp. v. Alliance Resources Corp., 509 U.S. 443, 460, 113 S.Ct. 2711, 2721–22, 125 L.Ed.2d 366 (1993).

In the present case DSHS has not alleged any damages at all. In fact the Department expressly declined to consider whether services were provided or not. DSHS asserted to Dr. Bircumshaw on the record that nobody would even ask him if services were provided or not. It was not a concern of the audit.

Despite the Department dismissing any interest to investigate whether any actual harm occurred, DSHS insists on demanding the return of approximately 65% of all payments made over three years. Their demand has no association at all with any actual harm, and it can only be characterized as a punishment for alleged technical violations of documentation guidelines, not regulations.

The Due Process Clause of the Fourteenth Amendment prohibits the imposition of grossly excessive or arbitrary punishments. Applying the BMW v. Gore guideposts validates the grossly excessive and arbitrary extent of the Departments imposition of punishment. The Supreme Court instructed courts to determine the reprehensibility of a defendant by considering whether: the harm caused was physical as opposed to economic; whether the tortious conduct evinced an indifference to or a reckless disregard of the health or safety of others; the target of the

conduct had financial vulnerability; the conduct involved repeated actions or was an isolated incident; and the harm was the result of intentional malice, trickery, or deceit, or mere accident. State Farm Mutual Automobile Insurance Company v. Campbell, 538 U.S. at 419.

Bircumshaw did not cause physical harm. No economic harm is even alleged. His conduct did not involve the safety of others or confront a party that was financially vulnerable. There is no allegation of malice or deceit. There is no alleged compensatory harm. For the third guidepost, a comparison of the punitive damage and civil penalties from comparable cases, there are no known comparable cases.

VII. Conclusion and Request For Relief

Federal and State authority direct the Department to make payment when medically necessary and covered services are provided to eligible beneficiaries. The State's own medical records confirm that services were provided. Denying payment in such a circumstance would generate an unjust enrichment to the State. The Department's demand for payment without showing of any actual harm amounts to an unauthorized punitive damage. The state's demand for 65% of all compensation over three years without any showing of actual harm is a violation of substantive due process. This Court should reverse the Department and the Trial Court. Sufficient records were provided to substantiate medically necessary and

covered service, properly authorized when required were provided to eligible beneficiaries.

The audit conclusions were not reasonably based on the evidence and failed to meet the Department's own reliability standard. The reversal of certain findings, 3A and 3B, with the same records and facts as over 10 % of the 1A and 1B and 2 findings mandate reversal of this order.

Submitted on the 23rd day of October, 2014.

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Appendices:

A. DSHS Medicaid Records,
Airway Optical Orders

B. Reversed Findings 3A & 3B Recap

Appellant's Appendix A

State of Washington v. Bircumshaw

Court of Appeals Division II

45923-0-II

Airway Optical

USE ONLY FOR WASHINGTON STATE MEDICAID SERVICES

Tray #

Date Ordered: 8-18-03

PROVIDER NAME AND ADDRESS

Pacific Vision
HL Bircumshaw, OD
4620 Pacific Avenue
Tacoma, Washington
98408-7738

	SPHERE	CYLINDER	AXIS	PRISM	BASE	DECENTRATION
R	-0.25	-0.50	180			
L	-0.25	-0.50	170			

	ADD POWER	HEIGHT	WIDTH	INSET	TOTAL INSET	PUPILLARY WIDTH	
						DISTANCE	NEAR
R							
L						63	

Single Vision | Flat Top | Round | 7x28 Trifocal | Other | Safety

Glass ☐ | Plastic ☐ | Other ☐ | Scratch Coat ☐ | Tint ☐

Frame Name	Eye Size	DBL	Temple Length	Temple Type	Circ.
Modern Charger Full Gold	44	18	130	STD	

SPECIAL INSTRUCTIONS

ALL ITEMS IN THIS SECTION MUST BE FILLED OUT COMPLETELY

PATIENT NAME (LAST, FIRST, MI) [redacted]

PIC NO. [redacted]

ICD-9 DX CODE

PRIOR AUTHORIZATION #

PROVIDER # 2108603- ☐

Drop Ball

Final Insp.

FAX TO:

Airway Optical

Fax: 1-888-606-7789

Call Toll Free: 1-888-606-7788

Please Print Clearly

MEDICAL RECORD # 894585

NUMERICALLY CONTROLLED FORM

USE ONLY ONCE

FOR FAX USE ONLY

A COPY OF THE

CLIENT'S DSHS COUPON

MUST BE ATTACHED HERE

Global 92340
order includes
verifying, + disp.

5+ N 1 1

4

Apr 07 06 12:03p p.6

Please read the back of this card.

[redacted]

MEDICAL IDENTIFICATION CARD

This Card Valid From: 04/01/2006
To: 04/30/2006
R01
LANGUAGE: RUSSIAN

Patient Identification Code (PIC)

Initials	Birthdate	Last Name	TB	Insurance	Medicare	HMO	Detox	Restriction	Hospice	DD Client	Other
[redacted]	[redacted]	[redacted]	[redacted]								

MELIA [redacted]

CNP

048 013228556
R000087713

SHOW TO MEDICAL PROVIDER AT TIME OF EACH SERVICE
DSHS 06-028 (REVISED 04/2004)

NOT TRANSFERABLE

SIGNATURE (Not Valid Unless Signed)

COP

Record 111

Airway Optical

11919 W. Sprague Ave
P O Box 1959
Airway Heights, WA 99001-1959
Phone: 888-606-7788
Fax: 888-606-7789

Provider Name & Address: Pacific V[illegible]
[illegible], OD
4626 Pacific Avenue
Tacoma, Washington
98408-7738

Tray No. 629

Match Patient's Eligibility Period >> Order Date: 04-06-06

Provider ID Number: 2 1 0 8 6 0 3 — 1 383086

ORDER DATE & PROVIDER NO. ARE REQUIRED

SV	RD 22	PolyCarb >	Authorization or ICD Codes
FT 22	7x28	Hi Index >	870000 [illegible]
FT 28	Other	Tint	<< Color

	Sphere	Cylinder	Axis	PD - Distance	PD - Near	Final Insp.
R	+2.75	DS			63	TB
L	+2.75	DS				

	Add Power	Height	Width	Prism	Base	Prism	Base
R							
L							

Please Verify All Necessary Prescription Information Has Been Included !!! Order Date, Axis, Pupillary Distance & Frame Color Are Often Overlooked.

Special Intructions: Sizer — Now Adapt lenses only

Frame Name & Color: EMF 919

Eye Size	DBL	Temple	Circ
52	20	135	

Patient Name Last, First, M.I.: [redacted]

Patient ID No.: [redacted]

1 383086

Always Required: Provider ID No. Patient ID No. Patient Name Date Ordered

NUMERICALLY CONTROLLED FORM - USE ONLY ONCE!

SHPD APR 17 2006

04/07/2006 FRI 09:39 [TX/RX NO 7535]

Exhibit 42
Page 1 of 2

1/1 hI ×3

Please read the back of this card.

MEDICAL IDENTIFICATION CARD
Department of Social & Health Services
This Card Valid From: 02/01/2005
F06 To: 02/28/2005
LANGUAGE: SPANISH

PO BOX 2277
TACOMA WA 98401-2277

0602301 246693 - 0

Patient Identification Code (PIC)				Medical Coverage Information							
Initials	Birthdate	Last Name	TB	Insurance	Medicare	HMO	Detox	Restriction	Hospice	DD Client	Other
C-	[redacted]	[redacted]	A			CHPW					
R-	[redacted]	[redacted]	A			CHPW					

CNP

[redacted] ST
[redacted] WA
98404-4439

800-440-1561 CHPW
131 007186922
R000085022

SHOW TO MEDICAL PROVIDER AT TIME OF EACH SERVICE
DSHS 06-020 (REVISED 04/2004)

[redacted] NOT TRANSFERABLE
SIGNATURE (Not Valid Unless Signed)

023240
Robert

NUMERICALLY CONTROLLED FORM USE ONLY ONCE!

Airway Optical
Correctional Industries
11919 W. Sprague Ave.
P. O. Box 1959
Airway Heights, WA 99001-1959
Call Toll Free: 1-888-606-7788
Or Fax At: 1-888-606-7789

Provider Name and Address:

FILL IN PHESCRIPTION INFORMATION BELOW

Single Vision: [x] Flat Top 28 [ ] Round [ ] 7 x 28 Trifocal [ ] Scratch Coat [ ]
Glass [ ] Polycarb [ ] Hi Index [ ] Other PLASTIC [x] Tint [ ]

	SPHERE	CYLINDER	AXIS	PUPILLARY WIDTH DISTANCE	NEAR
R	+0.75	-0.25	005	54	
L	+1.00	-0.50	013		

	ADD POWER	HEIGHT	WIDTH	PRISM	BASE	PRISM	BASE
R							
L							

Frame Name: Lollipop
Frame Color: Skull D. Amb

Eye Size	DBL	Temple Length	Temple Type	Circ.
39	20			

Special Instructions:

ALL ITEMS IN THIS SECTION MUST BE FILLED OUT COMPLETELY

Date Ordered: 02/14/05
Provider Number: 2108603-
Patient Name: (LAST, FIRST, MI) [redacted]
ID NO. [redacted]
Authorization Numbers:

FOR AIRWAY OPTICAL USE ONLY

Date Received: SHPD FEB 23 2005
Medical Record Number: 1114997
Tray Number: B807
Reference:
Drop Ball
Final Insp. 91

KINX

Appellant's Appendix B

State of Washington v. Bircumshaw

Court of Appeals Division II

45923-0-II

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
1	20	02/24/06	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	04/03/06	$103.78	$30.20	$73.58	2	Incorrect level of E/M code billed
2	20	04/23/04	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	07/26/04	$113.50	$23.75	$89.75	2	Incorrect level of E/M code billed
3	20	01/13/06	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	01/23/06	$113.92	$24.08	$89.84	2	Incorrect level of E/M code billed
4	2	04/06/06	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	04/24/06	$20.44	$0.00	$20.44	1A, 3A	No documentation for the procedure billed Fitting of spectacles also billed
5	4	03/11/04	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	03/29/04	$22.28	$0.00	$22.28	3A	Fitting of spectacles also billed
6	20	11/17/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	12/05/05	$113.92	$24.08	$89.84	2	Incorrect level of E/M code billed

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
7	8	08/08/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	08/22/05	$27.93	$0.00	$27.93	1B	No chart note
8	14	06/15/04	92310	FITTING/DISPENSING OF CONTACT LENS	06/28/04	$52.78	$0.00	$52.78	1B	No chart note
10	20	06/06/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF	07/11/05	$115.25	$43.25	$72.00	2	Incorrect level of E/M code billed
12	17	06/06/05	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	06/20/05	$77.08	$38.77	$38.31	2	Incorrect level of E/M code billed
14	20	02/08/06	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	02/20/06	$103.78	$30.20	$73.58	2	Incorrect level of E/M code billed
15	16	06/16/04	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	07/05/04	$76.21	$41.86	$34.35	2	Incorrect level of E/M code billed
16	3	02/08/05	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	02/21/05	$21.96	$0.00	$21.96	1A, 3A	No documentation for the procedure billed Fitting of spectacles also billed

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
17	6	08/18/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	09/15/03	$24.80	$0.00	$24.80	1A	No documentation for the procedure billed
19	20	05/08/06	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	05/22/06	$103.78	$30.20	$73.58	2	Incorrect level of E/M code billed
20	4	09/02/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	09/19/05	$24.75	$0.00	$24.75	1B	No chart note
21	6	08/21/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	09/15/03	$24.80	$0.00	$24.80	4C	Required interval between fitting not met
23	8	06/29/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/11/05	$24.80	$0.00	$24.80	1B	No chart note
24	4	03/22/04	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	04/05/04	$22.28	$0.00	$22.28	3A	Fitting of spectacles also billed
25	8	04/21/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/02/05	$24.80	$0.00	$24.80	4C	Required interval between fitting not met

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
26	6	12/22/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	01/12/04	$24.80	$0.00	$24.80	1A	No documentation for the procedure billed
27	8	05/13/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/23/05	$24.80	$0.00	$24.80	1B	No chart note
28	3	10/23/03	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	11/10/03	$22.28	$0.00	$22.28	1A	No documentation for the procedure billed
30	19	04/27/04	66984	EXTRACAPSULAR CATARACT REMOVAL	06/14/04	$82.67	$0.00	$82.67	1B	No chart note
31	7	10/27/04	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	11/08/04	$24.80	$0.00	$24.80	1A	No documentation for the procedure billed
32	2	02/23/06	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	03/06/06	$20.44	$0.00	$20.44	3A	Fitting of spectacles also billed
34	10	05/13/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	05/23/05	$27.98	$0.00	$27.98	1B	No chart note
36	8	04/18/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/02/05	$24.80	$0.00	$24.80	1B	No chart note

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
37	8	06/20/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/04/05	$24.80	$0.00	$24.80	1B	No chart note
38	8	09/21/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	10/10/05	$27.93	$0.00	$27.93	1B	No chart note
39	4	07/20/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	08/01/05	$24.75	$0.00	$24.75	1B	No chart note
40	8	05/20/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	06/13/05	$24.80	$0.00	$24.80	1B, 4C, 3B	No chart note Required interval between fitting not met Repair and refitting billed on same date
41	17	05/19/05	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	09/05/05	$77.08	$38.77	$38.31	2	Incorrect level of E/M code billed
42	20	11/19/03	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	01/12/04	$113.50	$0.00	$113.50	1A	No documentation for the procedure billed
43	8	04/06/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/16/05	$24.80	$0.00	$24.80	1B	No chart note

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
44	20	02/10/06	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	03/13/06	$113.92	$24.08	$89.84	2	Incorrect level of E/M code billed
45	20	04/28/06	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	05/22/06	$103.78	$34.75	$69.03	2	Incorrect level of E/M code billed
46	4	06/23/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/14/03	$24.12	$0.00	$24.12	1B	No chart note
48	10	04/26/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	05/09/05	$27.98	$0.00	$27.98	1B, 4C	No chart note Required interval between fitting not met
49	11	07/21/03	99202	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 20 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF LOW TO MODERATE SEVERITY	08/18/03	$42.25	$24.75	$17.50	2	Incorrect level of E/M code billed
50	8	07/25/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	08/08/05	$27.93	$0.00	$27.93	1B	No chart note
51	7	08/11/04	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	08/23/04	$24.80	$0.00	$24.80	3B	Repair and refitting billed on same date

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
52	4	07/20/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	08/01/05	$24.75	$0.00	$24.75	1B	No chart note
53	5	01/06/06	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	01/23/06	$24.75	$0.00	$24.75	1B	No chart note
54	2	01/31/06	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	02/13/06	$20.44	$0.00	$20.44	3A, 1B	Fitting of spectacles also billed No chart note
55	7	10/04/04	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	10/18/04	$24.80	$0.00	$24.80	1B	No chart note
56	8	04/19/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/02/05	$24.80	$0.00	$24.80	1B, 4C	No chart note Required interval between fitting not met
57	3	09/23/03	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	10/20/03	$22.28	$0.00	$22.28	3A, 1B	Fitting of spectacles also billed No chart note
58	16	10/04/04	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	10/18/04	$77.08	$0.00	$77.08	1C	No required history

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
60	8	12/12/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	12/26/05	$27.93	$0.00	$27.93	1B	No chart note
61	12	09/14/05	92015	DETERMINATION OF REFRACTIVE STATE	09/26/05	$43.15	$0.00	$43.15	1A	No documentation for the procedure billed
62	20	06/08/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	06/27/05	$115.25	$24.25	$91.00	2	Incorrect level of E/M code billed
63	8	06/29/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/11/05	$24.80	$0.00	$24.80	1B	No chart note
64	4	12/10/03	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	01/12/04	$22.28	$0.00	$22.28	1A	No documentation for the procedure billed
65	20	03/13/06	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	03/27/06	$103.78	$30.20	$73.58	2	Incorrect level of E/M code billed
67	20	11/19/04	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	12/27/04	$115.25	$24.25	$91.00	2	Incorrect level of E/M code billed

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
68	10	04/12/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	04/25/05	$27.98	$0.00	$27.98	1B	No chart note
69	7	09/30/04	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	10/11/04	$24.80	$0.00	$24.80	1B	No chart note
71	8	09/30/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	10/24/05	$27.93	$0.00	$27.93	1B, 4C	No chart note Required interval between fitting not met
72	8	05/11/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/23/05	$24.80	$0.00	$24.80	1B, 4C	No chart note Required interval between fitting not met
73	15	01/23/06	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	02/27/06	$54.36	$25.56	$28.80	2	Incorrect level of E/M code billed
75	8	12/05/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	12/19/05	$27.93	$0.00	$27.93	1B, 4C	No chart note Required interval between fitting not met
76	4	07/06/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/18/05	$24.75	$0.00	$24.75	1B	No chart note
77	8	06/30/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/11/05	$24.80	$0.00	$24.80	1B, 4C	No chart note Required interval between fitting not met

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
78	4	11/14/03	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	12/01/03	$22.28	$0.00	$22.28	1A, 3A	No documentation for the procedure billed Fitting of spectacles also billed
79	4	01/12/04	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	01/26/04	$22.28	$0.00	$22.28	3A	Fitting of spectacles also billed
80	4	08/31/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	09/12/05	$24.75	$0.00	$24.75	1B	No chart note
81	8	07/06/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	09/19/05	$27.93	$0.00	$27.93	1B	No chart note
82	20	01/12/05	99215	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT 40 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	01/31/05	$109.60	$25.25	$84.35	2	Incorrect level of E/M code billed
83	6	09/22/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	11/17/03	$24.80	$0.00	$24.80	1B	No chart note
84	3	06/19/03	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/07/03	$21.78	$0.00	$21.78	3A, 1B	Fitting of spectacles also billed No chart note

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
86	4	08/26/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	09/12/05	$24.75	$0.00	$24.75	1B, 4C	No chart note Required interval between fitting not met
87	17	02/18/05	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	03/07/05	$77.08	$42.39	$34.69	2	Incorrect level of E/M code billed
92	8	01/09/06	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	01/23/06	$27.93	$0.00	$27.93	1B, 3B	No chart note Repair and refitting billed on same date
93	10	04/20/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	05/02/05	$27.98	$0.00	$27.98	1B	No chart note
96	15	08/20/03	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	09/15/03	$54.00	$34.50	$19.50	2	Incorrect level of E/M code billed
97	9	02/27/06	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	03/13/06	$27.93	$0.00	$27.93	1B, 4C	No chart note Required interval between fitting not met
98	8	07/14/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	08/01/05	$27.93	$0.00	$27.93	1B, 4C	No chart note Required interval between fitting not met
99	4	06/20/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/14/03	$24.12	$0.00	$24.12	1B, 4C	No chart note Required interval between fitting not met

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
100	14	03/30/04	92310	FITTING/DISPENSING OF CONTACT LENS	04/12/04	$52.78	$0.00	$52.78	1A	No documentation for the procedure billed
101	8	08/26/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	09/12/05	$27.93	$0.00	$27.93	1B	No chart note
102	18	05/05/06	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	05/29/06	$78.12	$42.92	$35.20	2	Incorrect level of E/M code billed
103	20	12/03/04	99215	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT 40 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	12/20/04	$109.60	$24.25	$85.35	2	Incorrect level of E/M code billed
106	11	10/14/05	99213	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 15 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF LOW TO MODERATE SEVERITY	10/24/05	$34.75	$25.56	$9.19	2	Incorrect level of E/M code billed
108	5	11/28/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	01/02/06	$24.75	$0.00	$24.75	1B	No chart note
113	7	02/14/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	02/28/05	$24.80	$0.00	$24.80	1B	No chart note

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
114	16	03/29/04	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	04/12/04	$76.21	$37.99	$38.22	2	Incorrect level of E/M code billed
116	20	01/24/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	02/07/05	$115.25	$0.00	$115.25	4A	Erroneous billing
117	2	03/17/06	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	04/03/06	$20.44	$0.00	$20.44	3A	Fitting of spectacles also billed
119	8	04/06/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	04/18/05	$24.80	$0.00	$24.80	4C, 3B	Required interval between fitting not met Repair and refitting billed on same date
120	15	09/26/05	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	10/24/05	$54.36	$25.56	$28.80	2	Incorrect level of E/M code billed
121	14	06/09/04	92310	FITTING/DISPENSING OF CONTACT LENS	06/28/04	$52.78	$0.00	$52.78	1A	No documentation for the procedure billed
124	4	07/08/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/25/05	$24.75	$0.00	$24.75	1B, 4C	No chart note Required interval between fitting not met

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
125	8	06/04/03	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	06/23/03	$27.30	$0.00	$27.30	1B, 4C	No chart note Required interval between fitting not met
126	4	06/20/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/14/03	$24.12	$0.00	$24.12	1B	No chart note
127	8	11/03/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	11/14/05	$27.93	$0.00	$27.93	1B	No chart note
128	11	08/22/03	99202	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 20 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF LOW TO MODERATE SEVERITY	09/15/03	$42.25	$24.75	$17.50	2	Incorrect level of E/M code billed
129	5	01/19/06	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	01/30/06	$24.75	$0.00	$24.75	1B, 4C, 3B	No chart note Required interval between fitting not met Repair and refitting billed on same date
131	17	02/16/05	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	07/11/05	$77.08	$42.39	$34.69	2	Incorrect level of E/M code billed
133	4	12/02/03	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	12/15/03	$22.28	$0.00	$22.28	1A	No documentation for the procedure billed

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
137	20	07/16/04	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	08/23/04	$115.25	$0.00	$115.25	4A	Erroneous billing
139	8	05/10/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/23/05	$24.80	$0.00	$24.80	1B, 4C	No chart note Required interval between fitting not met
140	15	03/02/05	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	03/14/05	$55.00	$14.25	$40.75	2	Incorrect level of E/M code billed
141	20	10/18/04	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	11/01/04	$115.25	$30.38	$84.87	2	Incorrect level of E/M code billed
142	19	11/23/04	66984	EXTRACAPSULAR CATARACT REMOVAL	12/27/04	$83.15	$0.00	$83.15	4A	Erroneous billing
143	14	05/17/06	92310	FITTING/DISPENSING OF CONTACT LENS	05/29/06	$53.37	$0.00	$53.37	1A	No documentation for the procedure billed
144	15	01/27/06	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	02/13/06	$54.36	$25.56	$28.80	2	Incorrect level of E/M code billed

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
145	11	12/09/05	99213	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 15 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF LOW TO MODERATE SEVERITY	12/26/05	$34.75	$25.56	$9.19	2	Incorrect level of E/M code billed
146	8	05/27/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	06/13/05	$24.80	$0.00	$24.80	1B, 4C	No chart note Required interval between fitting not met
147	1	04/21/05	92390	SUPPLY OF SPECTACLES, EXCEPT PROSTHESIS	05/02/05	$16.50	$0.00	$16.50	1A	No documentation for the procedure billed
149	4	07/06/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/18/05	$24.75	$0.00	$24.75	1B, 4C	No chart note Required interval between fitting not met
150	3	02/15/05	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	02/28/05	$21.96	$0.00	$21.96	1A	No documentation for the procedure billed
152	20	02/03/06	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	02/20/06	$113.92	$24.08	$89.84	2	Incorrect level of E/M code billed
153	18	05/27/05	99215	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT 40 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	06/13/05	$79.75	$25.25	$54.50	2	Incorrect level of E/M code billed

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
154	18	02/23/05	99215	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT 40 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	03/07/05	$79.75	$35.25	$44.50	2	Incorrect level of E/M code billed
155	15	03/24/06	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	04/10/06	$54.36	$25.56	$28.80	2	Incorrect level of E/M code billed
156	19	01/16/04	99204	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 45 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	02/02/04	$89.00	$42.25	$46.75	2	Incorrect level of E/M code billed
157	1	01/20/04	92390	SUPPLY OF SPECTACLES, EXCEPT PROSTHESIS	02/02/04	$16.50	$0.00	$16.50	1A	No documentation for the procedure billed
158	4	12/31/03	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	01/19/04	$22.28	$0.00	$22.28	3A, 1B	Fitting of spectacles also billed No chart note
159	20	08/24/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	09/05/05	$113.92	$24.08	$89.84	2	Incorrect level of E/M code billed

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
160	17	06/27/05	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	07/11/05	$77.08	$42.39	$34.69	2	Incorrect level of E/M code billed
161	8	07/22/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	08/08/05	$27.93	$0.00	$27.93	1B	No chart note
162	8	06/15/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	06/27/05	$24.80	$0.00	$24.80	1B	No chart note
163	8	03/14/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	03/28/05	$24.80	$0.00	$24.80	1B, 3B	No chart note Repair and refitting billed on same date
166	20	04/21/06	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	05/08/06	$103.78	$30.20	$73.58	2	Incorrect level of E/M code billed
167	9	10/29/04	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	01/17/05	$27.98	$0.00	$27.98	4C	Required interval between fitting not met
168	10	06/13/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	06/27/05	$27.98	$0.00	$27.98	1B	No chart note

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
169	20	03/30/06	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	04/17/06	$103.78	$55.19	$48.59	2	Incorrect level of E/M code billed
170	3	08/11/03	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	09/15/03	$22.28	$0.00	$22.28	1A	No documentation for the procedure billed
171	4	06/27/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/21/03	$24.12	$0.00	$24.12	1B	No chart note
172	8	01/23/06	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	02/06/06	$27.93	$0.00	$27.93	1B	No chart note
173	15	03/03/04	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	04/12/04	$54.00	$24.75	$29.25	2	Incorrect level of E/M code billed
174	8	04/05/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	04/18/05	$24.80	$0.00	$24.80	1B	No chart note
176	1	04/06/04	92390	SUPPLY OF SPECTACLES, EXCEPT PROSTHESIS	04/19/04	$16.50	$0.00	$16.50	1A	No documentation for the procedure billed

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
177	17	12/27/04	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	01/03/05	$77.08	$42.39	$34.69	2	Incorrect level of E/M code billed
179	20	08/19/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	02/13/06	$113.92	$25.56	$88.36	2	Incorrect level of E/M code billed
181	20	06/02/04	99215	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT 40 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	06/14/04	$112.56	$24.75	$87.81	2	Incorrect level of E/M code billed
182	4	06/02/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	06/23/03	$24.12	$0.00	$24.12	1B, 1D	No chart note No lab ordering form
183	17	04/24/06	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	05/08/06	$78.12	$0.00	$78.12	1C	No required history
184	8	11/02/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	11/14/05	$27.93	$0.00	$27.93	1B	No chart note

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
185	18	05/26/06	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	06/12/06	$78.12	$42.92	$35.20	2	Incorrect level of E/M code billed
186	10	05/27/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	06/13/05	$27.98	$0.00	$27.98	1B	No chart note
187	7	12/30/04	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	01/10/05	$24.80	$0.00	$24.80	1B, 4C	No chart note Required interval between fitting not met
188	17	11/18/05	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	12/05/05	$78.12	$0.00	$78.12	4A	Erroneous billing
190	11	06/02/04	92310	FITTING/DISPENSING OF CONTACT LENS	06/14/04	$35.00	$0.00	$35.00	1B, 3B	No chart note Repair and refitting billed on same date
192	4	08/17/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	08/29/05	$24.75	$0.00	$24.75	1B, 4C	No chart note Required interval between fitting not met
193	4	05/04/04	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	08/16/04	$22.28	$0.00	$22.28	1A	No documentation for the procedure billed
195	9	08/17/04	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	08/30/04	$27.98	$0.00	$27.98	1B	No chart note

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
196	6	03/05/04	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	03/22/04	$24.80	$0.00	$24.80	1B, 4C, 1D	No chart note Required interval between fitting not met No lab ordering form
197	16	08/08/03	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	02/23/04	$76.21	$0.00	$76.21	4A	Erroneous billing
199	8	10/31/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	11/14/05	$27.93	$0.00	$27,93	1B	No chart note
200	4	09/06/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	09/19/05	$24.75	$0.00	$24.75	4C, 3B	Required interval between fitting not met Repair and refitting billed on same date
201	3	06/02/03	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	06/23/03	$21.78	$0.00	$21.78	3A	Fitting of spectacles also billed
202	8	03/23/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	04/04/05	$24.80	$0.00	$24.80	1B	No chart note
203	8	06/07/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	06/20/05	$24.80	$0.00	$24.80	4A	Erroneous billing
204	9	03/22/06	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	04/03/06	$27.93	$0.00	$27.93	4C	Required interval between fitting not met

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
206	1	10/10/05	92390	SUPPLY OF SPECTACLES, EXCEPT PROSTHESIS	10/24/05	$15.17	$0.00	$15.17	1A, 4C, 3B	No documentation for the procedure billed Required interval between fitting not met Repair and refitting billed on same date
207	1	12/05/05	92390	SUPPLY OF SPECTACLES, EXCEPT PROSTHESIS	12/19/05	$15.17	$0.00	$15.17	1A, 4C, 3B	No documentation for the procedure billed Required interval between fitting not met Repair and refitting billed on same date
208	4	06/11/04	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	06/28/04	$22.28	$0.00	$22.28	1A	No documentation for the procedure billed
209	16	01/26/04	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	02/09/04	$76.21	$41.86	$34.35	2	Incorrect level of E/M code billed
210	17	06/23/03	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	07/14/03	$77.35	$42.32	$35.03	2	Incorrect level of E/M code billed
211	20	04/22/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	08/08/05	$115.25	$25.25	$90.00	2	Incorrect level of E/M code billed

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Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
212	8	04/04/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	04/18/05	$24.80	$0.00	$24.80	1B	No chart note
213	8	06/18/03	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	07/07/03	$27.30	$0.00	$27.30	1B, 3B	No chart note Repair and refitting billed on same date
217	15	10/01/04	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	10/18/04	$55.00	$14.25	$40.75	2	Incorrect level of E/M code billed
218	14	05/09/05	92310	FITTING/DISPENSING OF CONTACT LENS	05/23/05	$53.05	$0.00	$53.05	1B	No chart note
219	15	09/02/05	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	09/19/05	$54.36	$25.56	$28.80	2	Incorrect level of E/M code billed
220	15	09/24/04	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	10/11/04	$55.00	$25.25	$29.75	2	Incorrect level of E/M code billed
222	2	03/06/06	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	03/20/06	$20.44	$0.00	$20.44	1A	No documentation for the procedure billed

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
223	20	08/26/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	09/12/05	$113.92	$24.08	$89.84	2	Incorrect level of E/M code billed
225	8	09/02/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	09/19/05	$27.93	$0.00	$27.93	1B	No chart note
226	20	10/28/05	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	11/21/05	$103.78	$30.20	$73.58	2	Incorrect level of E/M code billed
229	20	11/16/05	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	11/28/05	$103.78	$0.00	$103.78	4B	Double billing
230	8	03/28/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	04/11/05	$24.80	$0.00	$24.80	1B, 4C	No chart note Required interval between fitting not met
231	20	09/28/05	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	11/07/05	$103.78	$30.20	$73.58	2	Incorrect level of E/M code billed

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
232	3	08/04/03	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	09/01/03	$22.28	$0.00	$22.28	1A	No documentation for the procedure billed
233	20	04/07/06	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	04/24/06	$103.78	$30.20	$73.58	2	Incorrect level of E/M code billed
234	14	11/05/04	92310	FITTING/DISPENSING OF CONTACT LENS	11/22/04	$53.05	$0.00	$53.05	1B	No chart note
236	5	03/17/06	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	04/03/06	$24.75	$0.00	$24.75	1B	No chart note
237	7	11/01/04	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	11/15/04	$24.80	$0.00	$24.80	1B	No chart note
239	14	12/30/04	67820	CORRECTION TRICHIASIS, EPILATION BY FORC	01/10/05	$46.47	$0.00	$46.47	1A	No documentation for the procedure billed
240	6	10/02/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	10/27/03	$24.80	$0.00	$24.80	1B, 3B	No chart note Repair and refitting billed on same date

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Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
243	15	03/31/06	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	04/17/06	$54.36	$25.56	$28.80	2	Incorrect level of E/M code billed
244	16	09/03/03	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	11/17/03	$76.21	$0.00	$76.21	1C	No required history
245	8	06/23/03	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	07/21/03	$27.30	$0.00	$27.30	1B	No chart note
246	20	08/03/04	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	11/15/04	$115.25	$0.00	$115.25	4A	Erroneous billing
247	19	07/06/04	66984	EXTRACAPSULAR CATARACT REMOVAL	09/13/04	$83.15	$0.00	$83.15	1A	No documentation for the procedure billed
248	20	04/06/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	04/18/05	$115.25	$25.25	$90.00	2	Incorrect level of E/M code billed
249	10	04/15/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	04/25/05	$27.98	$0.00	$27.98	1B	No chart note

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
250	20	11/18/05	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	12/05/05	$103.78	$30.20	$73.58	2	Incorrect level of E/M code billed
251	20	08/03/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	08/22/05	$113.92	$24.08	$89.84	2	Incorrect level of E/M code billed
254	14	10/08/04	92310	FITTING/DISPENSING OF CONTACT LENS	10/25/04	$53.05	$51.10	$1.95	1B, 1D	No chart note No lab ordering form
255	8	04/29/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/16/05	$24.80	$0.00	$24.80	1B, 4C	No chart note Required interval between fitting not met
256	2	05/17/06	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/29/06	$20.44	$0.00	$20.44	3A, 1B, 4C	Fitting of spectacles also billed No chart note Required interval between fitting not met
257	5	05/17/06	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/29/06	$24.75	$0.00	$24.75	1B, 4C, 3B	No chart note Required interval between fitting not met Repair and refitting billed on same date
258	14	04/16/04	92310	FITTING/DISPENSING OF CONTACT LENS	05/03/04	$52.78	$0.00	$52.78	1D	No lab ordering form

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
260	16	12/05/03	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	01/12/04	$76.21	$0.00	$76.21	1C	No required history
261	14	04/26/04	92310	FITTING/DISPENSING OF CONTACT LENS	05/10/04	$52.78	$0.00	$52.78	1B	No chart note
265	9	01/09/04	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	01/26/04	$27.98	$0.00	$27.98	1B	No chart note
266	5	10/17/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	10/31/05	$24.75	$0.00	$24.75	1B	No chart note
267	10	05/31/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	06/13/05	$27.98	$0.00	$27.98	1B, 4C	No chart note Required interval between fitting not met
268	4	08/17/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	08/29/05	$24.75	$0.00	$24.75	1B	No chart note
270	14	05/04/05	92310	FITTING/DISPENSING OF CONTACT LENS	05/16/05	$53.05	$0.00	$53.05	1B	No chart note
271	4	11/20/03	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	12/01/03	$22.28	$0.00	$22.28	1A, 3A	No documentation for the procedure billed Fitting of spectacles also billed

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
272	5	05/10/06	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/22/06	$24.75	$0.00	$24.75	1B, 4C, 3B	No chart note Required interval between fitting not met Repair and refitting billed on same date
274	16	08/08/03	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	09/01/03	$76.21	$0.00	$76.21	1C	No required history
275	8	05/13/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/23/05	$24.80	$0.00	$24.80	4C	Required interval between fitting not met
276	11	05/04/05	92082	VISUAL FIELD EXAM, UNILATERAL/BILATERAL, W/INTERPRETATION & REPORT; INTERMEDIATE EXAM	05/16/05	$36.73	$0.00	$36.73	1A	No documentation for the procedure billed
277	8	05/19/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	06/13/05	$24.80	$0.00	$24.80	1B	No chart note
278	20	05/31/06	99244	OFFICE/OP CONSULTATION FOR NEW OR ESTABLISHED PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	07/03/06	$103.78	$55.19	$48.59	2	Incorrect level of E/M code billed
279	9	04/30/04	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	05/17/04	$27.98	$0.00	$27.98	1B	No chart note

Not Admitted

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
280	4	07/06/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/18/05	$24.75	$0.00	$24.75	1B	No chart note
281	8	10/31/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	11/14/05	$27.93	$0.00	$27.93	1B, 4C, 3B	No chart note Required interval between fitting not met Repair and refitting billed on same date
282	8	03/16/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	03/28/05	$24.80	$0.00	$24.80	1B	No chart note
283	17	10/20/05	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	10/31/05	$78.12	$0.00	$78.12	1C	No required history
284	16	08/03/04	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	08/16/04	$77.08	$0.00	$77.08	1C	No required history
285	19	08/18/03	99203	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 30 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE SEVERITY	10/20/03	$89.05	$0.00	$89.05	4A	Erroneous billing
287	1	10/11/05	92390	SUPPLY OF SPECTACLES, EXCEPT PROSTHESIS	10/24/05	$15.17	$0.00	$15.17	1A	No documentation for the procedure billed

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
289	17	04/04/05	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	04/18/05	$77.08	$0.00	$77.08	1C	No required history
291	4	06/30/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/21/03	$24.12	$0.00	$24.12	1B	No chart note
295	8	10/12/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	10/24/05	$27.93	$0.00	$27.93	1B, 4C, 3B	No chart note Required interval between fitting not met Repair and refitting billed on same date
296	8	07/11/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	07/25/05	$27.93	$0.00	$27.93	1B, 4C	No chart note Required interval between fitting not met
297	4	08/31/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	09/12/05	$24.75	$0.00	$24.75	1B	No chart note
298	9	07/02/03	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	07/28/03	$27.98	$0.00	$27.98	1B, 4C	No chart note Required interval between fitting not met
299	14	02/23/04	92310	FITTING/DISPENSING OF CONTACT LENS	03/08/04	$52.78	$0.00	$52.78	1B	No chart note
300	6	12/17/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	12/29/03	$24.80	$0.00	$24.80	1B	No chart note

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
301	14	05/19/04	92310	FITTING/DISPENSING OF CONTACT LENS	07/12/04	$52.78	$0.00	$52.78	1A	No documentation for the procedure billed
302	5	10/21/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	11/07/05	$24.75	$0.00	$24.75	1B	No chart note
303	14	08/29/03	9276M	FITTING FEE - CONTACT LENSES INCLUDES DISPENSING AND 30 DAY FOLLOW-UP CARE/RPLD BY 92314-92317	09/29/03	$46.33	$0.00	$46.33	3A, 1B, 1D	Fitting of spectacles also billed No chart note No lab ordering form
306	14	04/06/05	92310	FITTING/DISPENSING OF CONTACT LENS	04/18/05	$53.05	$0.00	$53.05	1B	No chart note
307	18	04/26/06	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	05/08/06	$78.12	$0.00	$78.12	4A	Erroneous billing
308	8	06/20/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/04/05	$24.80	$0.00	$24.80	1B, 4C	No chart note Required interval between fitting not met
309	8	01/17/06	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	01/30/06	$27.93	$0.00	$27.93	1B	No chart note
310	16	06/24/04	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	07/12/04	$76.21	$41.86	$34.35	2	Incorrect level of E/M code billed

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
311	6	09/10/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	10/13/03	$24.80	$0.00	$24.80	1B	No chart note
312	16	12/29/03	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	01/12/04	$76.21	$41.86	$34.35	2	Incorrect level of E/M code billed
313	17	06/25/03	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	08/04/03	$77.35	$0.00	$77.35	1C	No required history
314	9	01/22/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	01/31/05	$27.98	$0.00	$27.98	1D	No lab ordering form
315	4	05/24/04	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	07/12/04	$22.28	$0.00	$22.28	3A, 1B	Fitting of spectacles also billed No chart note
316	8	07/06/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	07/18/05	$27.93	$0.00	$27.93	1B, 4C	No chart note Required interval between fitting not met
317	4	06/13/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	08/04/03	$24.12	$0.00	$24.12	1B; 4C	No chart note Required interval between fitting not met

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
320	20	03/24/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	07/18/05	$115.25	$0.00	$115.25	4B	Double billing
321	18	07/27/05	99215	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT 40 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	08/15/05	$78.93	$25.56	$53.37	2	Incorrect level of E/M code billed
322	4	07/29/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	08/15/05	$24.75	$0.00	$24.75	1B, 4C	No chart note Required interval between fitting not met
323	1	05/17/05	92390	SUPPLY OF SPECTACLES, EXCEPT PROSTHESIS	05/30/05	$16.50	$0.00	$16.50	1A, 4C, 3B	No documentation for the procedure billed Required interval between fitting not met Repair and refitting billed on same date
324	17	01/08/05	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	02/07/05	$77.08	$42.39	$34.69	4A	Erroneous billing
325	17	01/24/05	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	02/07/05	$77.08	$0.00	$77.08	4A	Erroneous billing

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Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
326	14	03/18/05	92310	FITTING/DISPENSING OF CONTACT LENS	04/04/05	$53.05	$0.00	$53.05	1B	No chart note
327	11	08/30/04	92310	FITTING/DISPENSING OF CONTACT LENS	09/13/04	$35.00	$0.00	$35.00	1A, 3B	No documentation for the procedure billed Repair and refitting billed on same date
328	16	05/17/04	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	05/31/04	$76.21	$0.00	$76.21	1C	No required history
329	8	01/23/06	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	02/06/06	$27.93	$0.00	$27.93	1B	No chart note
330	2	04/10/06	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	04/24/06	$20.44	$0.00	$20.44	3A, 1B	Fitting of spectacles also billed No chart note
331	18	07/18/05	99215	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT 40 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	09/26/05	$78.93	$34.75	$44.18	2	Incorrect level of E/M code billed
333	11	02/28/05	99213	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 15 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF LOW TO MODERATE SEVERITY	03/14/05	$35.25	$14.25	$21.00	2	Incorrect level of E/M code billed

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Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
336	4	06/09/03	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	06/30/03	$24.12	$0.00	$24.12	1B	No chart note
337	10	06/28/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	08/01/05	$27.98	$0.00	$27.98	1B, 4C, 3B	No chart note Required interval between fitting not met Repair and refitting billed on same date
340	20	11/30/05	99205	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 60 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	12/12/05	$113.92	$25.56	$88.36	2	Incorrect level of E/M code billed
341	19	02/18/04	99204	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 45 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF MODERATE TO HIGH SEVERITY	03/01/04	$89.00	$34.50	$54.50	2	Incorrect level of E/M code billed
342	15	02/06/04	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	04/26/04	$54.00	$24.75	$29.25	2	Incorrect level of E/M code billed
343	15	02/09/04	99214	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT, 25 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	04/26/04	$54.00	$24.75	$29.25	2	Incorrect level of E/M code billed

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
344	17	03/03/06	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	03/13/06	$78.12	$0.00	$78.12	1C	No required history
345	7	08/25/04	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	09/06/04	$24.80	$0.00	$24.80	1B	No chart note
347	1	02/26/04	92390	SUPPLY OF SPECTACLES, EXCEPT PROSTHESIS	03/08/04	$16.50	$0.00	$16.50	1A	No documentation for the procedure billed
348	2	10/04/05	92370	REPAIR & REFITTING OF SPECTACLES EXCEPT FOR APHAKIA - INCLUDES DISPENSING	10/24/05	$20.44	$0.00	$20.44	1A	No documentation for the procedure billed
349	8	05/18/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/30/05	$24.80	$0.00	$24.80	1B, 4C	No chart note Required interval between fitting not met
350	8	03/16/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	03/28/05	$24.80	$0.00	$24.80	1A	No documentation for the procedure billed
353	8	08/09/05	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	08/22/05	$27.93	$0.00	$27.93	1B	No chart note
354	14	04/09/04	92310	FITTING/DISPENSING OF CONTACT LENS	04/26/04	$52.78	$0.00	$52.78	1B	No chart note

APPENDIX A

Projected Sample Overpayments

Record Number	Strata	Service Date	PROC Code	Procedure Description	Paid Date	Amount Paid	Audited Correct Amount	Overpaid Amount	Finding Number	Finding Description
356	15	09/22/03	99202	OFFICE & OTHER OP VISIT-EVAL/MGMT NEW PATIENT, 20 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS OF LOW TO MODERATE SEVERITY	10/20/03	$60.20	$24.75	$35.45	2	Incorrect level of E/M code billed
357	18	04/19/04	99215	OFFICE & OTHER OP VISIT-EVAL/MGMT ESTABLISHED PATIENT 40 MINUTES FACE-TO-FACE, PRESENTING PROBLEMS ARE OF MODERATE TO HIGH SEVERITY	06/28/04	$79.00	$24.75	$54.25	2	Incorrect level of E/M code billed
358	8	06/06/03	92341	FITTING OF SPECTACLES, BIFOCAL EXCEPT APHAKIA - INCLUDES DISPENSING	06/30/03	$27.30	$0.00	$27.30	3B	Repair and refitting billed on same date
359	17	01/05/05	92004	OPHTHALMOLOGICAL SERVICES; MEDICAL EXAM & EVALUATION; COMPHREHENSIVE, NEW PATIENT, ONE OR MORE VISITS	01/17/05	$77.08	$0.00	$77.08	1C	No required history
362	8	06/06/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	06/20/05	$24.80	$0.00	$24.80	1B	No chart note
363	8	03/16/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	03/28/05	$24.80	$0.00	$24.80	1B, 3B	No chart note Repair and refitting billed on same date
364	8	05/13/05	92340	FITTING OF SPECTACLES, MONOFOCAL EXCEPT FOR APHAKIA - INCLUDES DISPENSING	05/23/05	$24.80	$0.00	$24.80	1B	No chart note

NO. 45923-0-II
COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

STATE OF WASHINGTON, Plaintiff/Respondent, v. HAROLD BIRCUMSHAW Defendant/Appellant.	NO. **13-2-07068-1** DECLARATION OF SERVICE BY MAIL

KNOW ALL PERSONS BY THESE PRESENTS: That I, Stacey McKee, the undersigned, of Tacoma, in the County of Pierce and State of Washington, have declared and do hereby declare:

That I am not a party to the above-entitled action, am over the age required and competent to be a witness;

That on the 24th day of October, 2014, I placed in the United States Mail with first class postage prepaid an envelope containing the following documents:

1. Brief of Appellant,

2. This Declaration of Service by Mail

Properly addressed to the following:

Angela Coats McCarthy
Matthew Sailer King
P.O. Box 40124
7141 Cleanwater Dr SW
Olympia, WA 98504

I declare under penalty of perjury under the laws of the State of Washington and of the United States that the foregoing is true and correct.

Signed at Tacoma, Pierce County, Washington this 24th day of October, 2014.

Stacey McKee

Kram, Wooster, P.S.
1901 South I Street
Tacoma WA 98405
(253) 272-7929